MITCHELL E. DANIELS, Jr., Governor
STATE OF INDIANA

DEPARTMENT OF HOMELAND SECURITY JOSEPH E. WAINSCOTT, JR., EXECUTIVE DIRECTOR

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EMERGENCY MEDICAL SERVICES
TECHNICAL ADVISORY COMMITTEE MINUTES

DATE: August 3, 2010
10:00 A.M.

LOCATION: Brownsburg Fire Territory
470 E. Northfield Dr.
Brownsburg, IN 46112

MEMBERS PRESENT:	Leon Bell	Chairman, ALS Training Institute
	John Zartman	Vice-Chairman, ALS Program Director
	Tina Butt	Secretary, 1ST Responder Training Director
	Edward Bartkus	EMS Medical Director
	Sara Brown	EMS Medical Director
	Stephen Cox	EMS Chief Operating Officer
	Sherry Fetters	EMS Chief Executive Officer
	Charles Ford	EMS Chief Executive Officer
	Michael Gamble	Emergency Department Director
	Michael McNutt	BLS Training Program Director
	Faril Ward	EMS Chief Operating Officer
	Elizabeth Weinstein	EMS for Children
MEMBERS ABSENT:	Valerie Miller	Emergency Department Director
OTHERS PRESENT:	Rick Archer	State EMS Director
	Bruce Bare	State EMS Section Chief

A) Call to Order: Meeting was called to order by Chairman Bell.

B) ROLL CALL: Quorum present.

C) Adoption of minutes:

Sherry Fetters offered a motion to adopt the minutes. The motion was seconded by John Zartman. The motion passed.

Chairman Bell noted that Dr. Weinstein's name had not been included in the list of members in the minutes. Motion was made to add Dr. Weinstein and the motion passed.

D) Old Business

a. Meeting Locations – Gail Fennel IDHS is handling securing locations. The October meeting will probably be held south in Greensburg. Gail is trying to secure locations to mirror where the EMS Commission meeting is being held the previous month.
b. Supply Requests – Gail will handle after the meeting.
c. Submission requirements for public comment – Chairman Bell stated we could accept cards like they do at the commission or have the person raise their hand for comment.
    a. Mr. Archer suggested an area for Public Comment be added to the agenda. Chairman Bell requested to add Public Comment to the beginning of the agenda.

E) Announcements

a. Mr. Rick Archer
    i. Vision for the Future Workshop – the purpose is to look at the EMS System in Indiana and the 14 components of an EMS system developed by NHTSA. Some of the components need to be addressed more thoroughly. The original workshop date was proposed for September 2010. It has been postponed in order to seek grant monies. IDHS will be contracting with Purdue University to conduct the workshop and write the reports. Mr. Archer would like the TAC Committee to help identify some dates possibly in January to avoid conflicts with other activities occurring.

    ii. IDHS will be improving communication with the EMS Community by starting EMS Forums that will include all EMS stakeholders in each of the 10 districts. The tentative dates are: 9/10=District 7, 9/15=District 8, 9/21=District 5, 9/28=District 1, 9/29=District 2, 9/30=District 3, 10/8=District 4, 10/14=District 9, 10/15=District 10, 10/18=District 6. Mr. Archer requested a couple of TAC members attend each of the sessions but not too many to create a forum. Items that will be discussed during the EMS forums are Who's Who at the State level, information sharing, local needs, and concerns.

    iii. Mr. Archer announced a date change for September's commission meeting to the 24th.

b. Mr. Bruce Bare
    i. Mr. Bare has completed the PowerPoint presentation on the National Education Standards and the current Indiana EMS levels discussing similarities and differences. He is going to present this to the IDHS administrative staff and in the future to the TAC Committee.

    ii. Mr. Bare spoke with Bill Brown (Director of the National Registry) regarding grandfathering in current providers who are not registry now should Indiana adopt the National Registry for testing. Mr. Brown stated this cannot be done due to current accreditation. If a provider has had a past national registry certification then the provider would just have to reactivate it. Mr. Bare stated that Indiana may have to have a dual certification system for awhile until through attrition everyone would be National Registry. This was done in North Carolina and it took about 6-7 years. The current testing is designed for entry level students and older medics have had a high fail rate for taking this exam.

iii. Mr. Bare also spoke with Mr. Brown about increasing the amount of testing sites and the ability of the National Registry to handle the increase. Mr. Brown stated they would hire more operators for calls but the rest of the system is automated. He does acknowledge that we need to have more testing sites and this is something we would need to work on. Right now the National Registry allows the Training Institute to administer the practical at the EMT level.

1. Mr. Brown has offered to come to Indiana to meet with this committee.

2. Discussion continued regarding timelines from National Registry for implementation, publishers, and the NAEMSO timeline to assist Indiana in developing its own timeline. Mr. Archer stated Indiana is about a year and a half behind.

3. Chairman Bell states that National Registry has a new practical testing process in beta testing that will begin in August. They are looking for 24 sites across the county who are academic, hospital, fire department, public and private to field test the new process. He described it as a competency by portfolio. There are 66 essential skills that have to be verified by the instructor. The second component is scenarios. National Registry is looking at 3 Team Leader scenarios and 10 team member scenarios before students are released to hospital and field clinicals. After clinicals they have a summative evaluation then take a practical. The practical consists of 3 or 4 people in a testing site where there will be 3 or 4 scenarios. Everyone is expected to team lead and rotate like they do in ACLS and PHTLS courses now. National Registry expects this to be completed by the end of next year which coincides with their testing dates.

4. Chairman Bell stated that the 18 current accredited sites and the 4 waiver training institution sites for paramedics have to teach the National Standard Curriculum because this is a requirement of the accreditation from CoAEMSP.

5. Chairman Bell stated there are 3 things we need to address currently with the curriculum: 1. What do we do with the EMT-Basic Advanced we have now? 2. What do we do with the intermediates? 3. What do we do with the EMT's and First Responders? This is what today's subcommittee work will be.

c. Chairman Bell reminded committee members to complete their ethics training if not done.

F) Trauma System Rules

a. Mara Snyder gave the EMS Commission the TAC comments for review. Mr. Archer stated the commission will review the comments and discuss them at the September meeting. The rules will be posted on the website with an email link to solicit comments to Mr. Bare who will forward to the commission.

b. Mr. Archer stated that he has concerns for the fiscal impact in various areas throughout the state with criteria and timelines. He stated that the TAC is charged with looking at the fiscal impact to providers and what would that be. Mr. McNutt stated that the fiscal impact is also going to involve hospitals. Mr. Archer stated the fiscal impact needs to include all the stakeholders. Discussion continued regarding fiscal impact and the medical legal aspects if this becomes the standard of care that some communities may not be able to follow. Air Medical transport needs and who makes the decision to launch was also discussed. It was suggested this be addressed by a subcommittee.

G) New Business

New EMS Commission Tasks

a. Chairman Bell summarized events at the previous commission meeting regarding the TAC.
   i. There was a discussion regarding 24 hour ALS coverage and what does it mean in the current rules. There have been some different interpretations.
   ii. New paramedic program policy was discussed. There was a waiver request involved. The commission would like us to look at what the staff has produced.
   iii. There was discussion regarding defensive driving and the rules/conditions for who can drive an ambulance.
   iv. The commission has asked the TAC to research criminal background checks and drug testing for admission to all levels of EMS Education.

b. Chairman Bell stated with these new tasks and the tasks involving the new curriculum he wants to divide into subcommittees to work on these tasks. They are:
   i. 24 hour coverage and defensive driving
   ii. New paramedic program policies and drug screening
   iii. Trauma rules
   iv. New curriculum

c. Dr. Bartkus addressed the fact that there will always be a fiscal impact with all decisions. We need to look at what is best for the patient. Then address if there is a way to minimize the fiscal impact. Mr. Archer stated that a fiscal impact study needs to be completed for decisions but that doesn't mean it will not get approved.

d. Chairman Bell asked for volunteers for the subcommittee work. The 24 hour and driving group is Michael McNutt, Charles Ford, and Stephen Cox. The paramedic policy and drug testing group is Dr. Bartkus, John Zartman, and Sherry Fetters. The Curriculum group assigned at the previous meeting is John Zartman, Faril Ward, and Tina Butt. The Trauma group is Dr. Weinstein, Dr. Gamble, and Dr. Brown.

e. Chairman Bell asked that each group approach their topics through the process of identifying the problem, gather data which could include surveys, data analysis, fiscal impact, come up with solutions, pick 1 to recommend, and then look to evaluate the decision.

f. Mr. Archer stated that the public meeting should be recessed for subcommittee work.

H) Recess

A motion was made to recess until 1300 by Faril Ward and seconded by Charles Ford. The motion passed.

I) Reconvene Chairman Bell called the meeting reconvened.

J) Subcommittee reports

1. <u>Trauma:</u>
   a. Document lacks operational utility…in the current format the document cannot be easily understood or taught or implemented.
   b. Controversial issues regarding transport time guidelines:

i. ground transport vs. aeromedical activation
ii. decision to bypass local hospitals

c. Lack of integration and consistency between the document and the field triage decision scheme
    i. Revise section 3 (11) to include specific and unaltered language from the field triage decision scheme

A motion was made to send a comment letter outlining the 3 issues to the Sept. commission meeting and ask the EMS Commission to send the Trauma Rules back to this group for more work and revision. The revised recommendations would then be sent to the EMS commission in November. The motion was made by John Zartman and seconded by Faril Ward. Discussion continued regarding what is best for patient care and different areas within the state. The subcommittee will also be asking for information on how other states have handled this.
The motion passed.

2. <u>New Curriculum</u> = Recommendation (skeleton) Outline

    a. Indiana should accept the new model curriculum in association with national registry as a floor for use within Indiana
    b. A determination needs to be made concerning what skills, procedures or interventions Indiana EMS might lose at each new certification level (EMR, EMT, Advanced, Paramedic), and tools for adding those procedures to the new model be established.
    c. Bridge programs and Curriculum from current Basic-Advanced to Advanced and from current Intermediate to Paramedic need to be delineated and established.
    d. Methods of insuring that additions legislative and EMS Commission requirements such as, but not necessarily limited to, Autism, SIDS, & Hazmat Awareness are either included or added to the new curriculum at the EMT level.
    e. Issues with PI certification and alternatives need to be examined as part of an overall adoption of the new model curriculum.
    f. Reasonable time periods for implementation of all these features need to be established.
    g. There needs to be a Public Relations piece to explain what we are doing, why are doing it and get current certification holders at all levels on board.

    No comments received, report accepted as written.

3. <u>New paramedic program policies and drug screening</u>

    a. The discussion started with the issue of background checks and having EMS providers who are safe by the time they are doing clinicals and field time. It would start with a data set for a background check to be done before clinicals start. Along with a list of disqualifier acts consistent with what the state is doing now and looks at National Registry. This would be the training institutes' responsibility. Review of other states will also be addressed. The research will also include drug screening that is defensible. The recommendation will include checks be completed at every educational entry level including primary instructor. The first responder

will have to be addressed since there are no clinicals at that level. The subcommittee is meeting on August 17th. No recommendations at this time.

b. New Paramedic Program Policy= this is addressing new programs that want to teach at the paramedic level while obtaining accreditation. Reviewed what the state has currently been doing before sending to the EMS commission. One of the problems identified is the mentoring phase for the institution. The mentoring phase needs to be looked at so that problems do not arise. We want to also look at protection of the students who enter such a program and the institution receives major infractions or no accreditation. Starting with some surveys.

No recommendations at this time.

4. <u>24 hour coverage and defensive driving</u>

a. The first task was to review the considerations associated with the state requirement that an ALS service must operate 24 hours per day.
b. The second task was to review the use of non-EMS certified personnel to drive an ambulance.

Task 1

The sub-committee reviewed the requirement that an ALS provider must provide ALS 24 hours per day. Upon research the basis for the question was a waiver presented to the Indiana EMS Commission from an ALS provider who wished to provide non-emergency ALS coverage without having a complete crew on station. As the sub-committee understood it there was to be an ALS provider on call and a BLS crew member on-station with a response time for non-emergency transfers of 30 minutes.
The committee discussed the issue and the consensus was that this is something that should be allowed so long as it was a service that did not have a contract or a "duty to act" as a provider of emergency ALS response within that jurisdiction.
The sub-committee decided that it would be prudent to send out a questionnaire to better understand how it will affect providers.

Task 2

The subcommittee discussed non-EMS certified personnel driving an ambulance. As it was understood by the committee this was referred to the TAC by the EMS Commission to review as a result of a waiver request by a provider who wanted a non-EMS certified individual to be able to drive a specialty EMS vehicle.
A significant discussion regarding this issue ensued. The committee discussed this issue in a larger sense in that many volunteer EMS Departments utilize non-EMS certified individuals to respond as part of their crew. Disallowing this practice would likely impart significant hardship on many EMS services and would likely result in negative consequences.
The sub-committee felt that this was really a two-fold issue. The first issue of course being that the individuals were allowed to drive an ambulance with a patient on board with no knowledge of the rules and no experience in driving an emergency vehicle. The second issue is that it is envisioned by the sub-committee that there are times when the only individuals responding on a run could be a non-trained driver and an EMT. This would necessitate that the non-trained individual assist the EMT and assist in handling the patient, neither of which he or she is trained to do.
The sub-committee discussed the issues associated with the driving portion of the problem. The issue really extends to certified personnel as well as most initial education programs do not include any kind of driver training program above and beyond the lecture portion of the class. These individuals do at least have some

experience riding in the back of an ambulance due to the required clinical time and they do receive didactic training on emergency driving which includes driving dynamics and laws governing the emergency vehicle. The second part of the issue involving assisting the EMT and assisting in the handling of the patient was also extensively discussed. It was felt that an individual who functions in that role should know how to operate the cot, stair chair [if applicable] and be able to recognize key pieces of equipment carried on the ambulance that may be needed by the EMT. The goal would not be to train the individual how to use the equipment, only to recognize the equipment.
The solution that the sub-committee came up with was to develop a list of objectives that the provider must assure that a non-EMS certified driver must meet prior to allowing them to drive an ambulance in the emergency mode or with a patient on board. This must be documented by the provider and kept in the providers files and available for inspection by the EMS Commission upon request.
The criteria are:

- Review all applicable laws that pertain to emergency driving in the state of Indiana.
- Review the vehicle dynamics associated with ambulances and associated patient ride characteristics.
- With an Indiana certified EMS provider [EMT or higher] provide sufficient driving experience in the non-emergency mode without a patient on board to assure proficiency in the operation of the vehicle.
- Provide training on the operation of the ambulance cot to obtain proficiency
- Provide training on patient handling to include the various lifts and methods used for patient movement.
- Provide training on the stair chair if applicable.

Provide training so that the driver can recognize the following equipment:

- Non-rebreather
- AED
- Oxygen
- Portable suction unit
- Spinal immobilization devices
- Splinting devices
- OB kit
- Burn sheets

The sub-committee decided to send out a questionnaire to providers to sample the impact that this may have on their operations.

Discussion was held on the current rules and waivers that have been applied for. This included ALS emergent vs. non-emergent and BLS. What needs to be defined for everyone is what 24 hour ALS service is and how does this effect urban vs. rural areas of Indiana.

Driving laws and current practice in a variety of systems was discussed. Non-EMS vs. EMS certified driver's training compared. There are other ambulance operational issues to be discussed based on past waiver requests and current EVOC courses.

Dr. Bartkus made a motion to accept the report and to send out the survey. Faril Ward seconded. The motion passed.

K) Good of the order

Ms. Fetters asked if the TAC committee could request the EMS commission give the TAC its tasks in writing to decrease any confusion on the specific tasks we are asked to address. Could they also send representation? Mr. Archer is present at the TAC committee meetings and he is an EMS commission member. He stated that to ask for the tasks in writing would be okay.

L) Public Comment

There is a lot of discussion regarding driving and the new EMT on an EMS website. It anyone wants to review it. Speaker stated he thinks it is EMS 1

M) Next Meeting: October 5, 2010

Location to be announced

N) Adjournment:

A motion to adjourn was made by Dr. Brown and seconded by Dr. Weinstein.

The meeting was adjourned.

Approved_____

Leon Bell III, Chairman